Medical Assistance Provider Bulletin

Attention: All Title XIX Certified ESRD Providers

Subject: UB-92 Claim Form Implementation

Date: November 19, 1993
Code: MAPB-093-013-0

Department of Health and Social Services, Division of Health,
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

TABLE OF CONTENTS

This Medical Assistance Provider Bulletin (MAPB) provides important information on the Wisconsin Medical Assistance Program's (WMAP) implementation of the revised UB-92 (HCFA 1450) claim form. **It is important that providers review this information carefully and share it with billing staff.**

The Health Care Financing Administration (HCFA) has mandated that all state Medicaid programs implement the UB-92 (HCFA 1450) claim form. The WMAP is implementing this mandate according to the following guidelines:

PAPER CLAIMS

All paper claims received by EDS on or after **October 4, 1993**, but prior to April 4, 1994, may be submitted on either the UB-82 ***or*** the UB-92 claim form.

All paper claims, including adjustments and the resubmission of any previously denied claims, received by EDS on or after **April 4, 1994**, must be submitted on the UB-92. Claims received by EDS on or after April 4, 1994, on a claim form other than the UB-92 will be denied.

ELECTRONIC CLAIMS

All electronic claims transmitted to EDS on or after **January 1, 1994**, but prior to **4:00 PM central time on April 1, 1994**, may be submitted in either the UB-82 ***or*** UB-92 claim format. Magnetic tapes in the UB-82 format must be received by 2:00 PM central time on April 1, 1994.

All electronic claims, including the resubmission of any previously denied claims, received by EDS after **7:00 AM central time on April 4, 1994**, must be submitted in the UB-92 claim format. Claims received by EDS after 7:00 AM central time on April 4, 1994, in a claim format other than the UB-92 will be denied.

NOTE: In order to convert the claims processing system from the UB-82 to the UB-92 claim format, EDS will not accept electronic claim transmissions between 4:00 PM on April 1, 1994, and 7:00 AM on April 4, 1994.

The UB-92 claim form is not provided by either the WMAP or EDS, but may be obtained from a number of forms suppliers, including:

Standard Register
Post Office Box 6248
Madison, WI 53716
(608) 222-4131

Refer to Attachment 1 of this MAPB for UB-92 claim form instructions for ESRDs.

ATTACHMENTS

1. UB-92 Claim Form Completion Instructions for End-Stage Renal Disease Services

2. UB-92 Claim Form Sample

Attachment 1

UB-92 Claim Form Completion Instructions for End-Stage Renal Disease Services

To avoid denied claims or inaccurate reimbursement, providers must use these claim form completion instructions. Enter all required data on the claim form in the appropriate item. Do not include attachments unless instructed to do so. Only the identified elements are required.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card must always be presented prior to rendering the service. Please use the information exactly as it appears on the Medical Assistance identification card to complete the information in the "patient" and "insured" information sections.

ITEM 1 - PROVIDER NAME AND ADDRESS
Enter the name, address, city, state, and zip code of the billing provider.

ITEM 3 - PATIENT CONTROL NUMBER (optional)
Providers can enter up to 17 characters of the patient's internal office account number. This number will appear on the provider's Remittance and Status Report.

ITEM 4 - TYPE OF BILL
Enter bill type 721 in this item.

ITEM 6 - STATEMENT COVERS PERIOD
Enter the first date of service in the "from" column and the last date of service in the "through" column. The "Statement Covers Period" cannot span more than one calendar month per claim.

ITEM 7 - COV'D
Enter the total number of days of service in this item.

ITEM 12 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ITEM 42 - REVENUE CODE
Enter the appropriate revenue code.

Enter revenue code 001 on the last line, indicating the line on which the sum of all charges on the is placed.

ITEM 43 - DESCRIPTION
Enter the date of service in MMDDYY format either in this item or in item 45.

If a Current Procedural Technology Code, fourth edition (CPT-4) code is required for laboratory services, enter the procedure code in item 44.

When series billing (i.e., billing from two to four dates of service on the same line), indicate the dates in the following format: MMDDYY MMDD MMDD MMDD. Indicate the dates in ascending order.

Providers may enter up to four dates of service per line for each revenue or procedure code if:

- All dates of service are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.

If it is necessary to indicate more than four dates of service per revenue or procedure code, indicate the dates on subsequent lines. On paper claims, no more than 23 lines can be submitted on a single claim, including the "Total Charges" line.

ITEM 44 - HCPCS/RATES
If revenue code 300 is indicated in item 42, indicate the appropriate HCPCS laboratory code in item 44.

ITEM 45 - SERVICE DATES
Enter the date in MMDDYY format either in this item or in item 43. (Multiple dates of service are indicated in item 43.)

ITEM 46 - UNITS
Enter the total number of services billed on each line item.

ITEM 47 - TOTAL CHARGES
Enter the total charges for the service on each line item. For revenue code 001, enter the grand total for all services submitted on the claim.

ITEM 50 A, B, or C - PAYER
Indicate the WMAP ("T19-WI Medicaid") and all third-party payers (including Medicare) with possible involvement in this claim. <u>All coverage indicated on the recipient's Medical Assistance identification card must be addressed.</u>

ITEM 51 A, B, or C - MEDICAID NO.
Enter the billing provider's eight-digit Medical Assistance provider number on the "T19-WI Medicaid" line.

ITEM 54 A, B, or C - PRIOR PAYMENTS
If applicable, enter the amount the provider has received toward payment of this bill prior to the billing date by the indicated payer. If "other insurance" denied the claim, enter $0.00. (Do not indicate Medicare payments.)

File an "Other Coverage Discrepancy Report" (Appendix 19 of Part A of the WMAP Provider Handbook) if coverage listed on the recipient's Medical Assistance identification card disagrees with the recipient's statement.

ITEM 60 A, B, or C - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
On the "T19-WI Medicaid" line, enter the recipient's 10-digit Medical Assistance identification number from the current Medical Assistance identification card.

ITEM 67 - PRINCIPLE DIAGNOSIS
Enter the most specific International Classification of Disease, 9th edition, Clinical Modification (ICD-9-CM) diagnosis for each symptom or condition related to the services provided. Etiology ("E") codes may not be used as a primary diagnosis. Manifestation ("M") codes are not valid diagnosis codes for Medical Assistance.

ITEMS 68-75 - OTHER DIAGNOSIS CODES (OPTIONAL)
Additional diagnosis codes may be entered in these items.

ITEM 84 - REMARKS
This item is used for other health insurance and Medicare.

Bill other health insurance (commercial insurance coverage) prior to billing the WMAP, unless the service does not require other health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other coverage" of the recipient's Medical Assistance identification card is blank, the service does not require other health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, leave this element blank.

- When "Other coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires other health insurance billing according to Appendix 18a of Part A of WMAP Provider Handbook, indicate one of the following codes. The description, policy holder, plan name, group number, etc. are not required.

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to: - recipient denies coverage or will not cooperate; - the provider knows the service in question is noncovered by the carrier; - insurance failed to respond to initial and follow-up claim; or - benefits not assignable or cannot get an assignment.

- When "Other coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover the service or the billed amount does not exceed the coinsurance and deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation amount.

Bill Medicare before billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes (the description is not required):

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

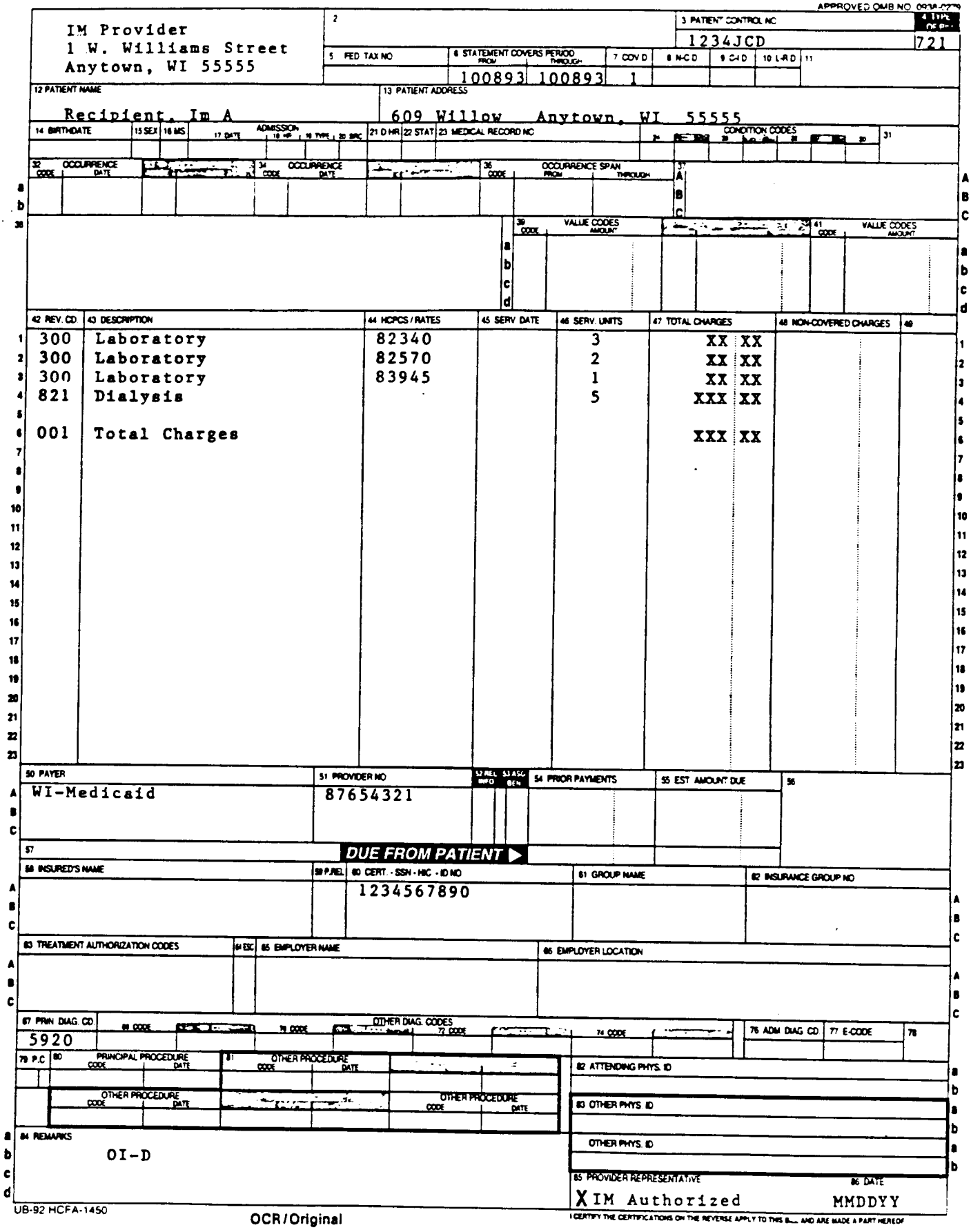
If Medicare is not billed because the recipient's Medical Assistance identification card indicates no Medicare coverage, leave this item blank.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare benefits (EOMB) to the claim and leave this item blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for more information on submitting dual entitlee claims.

ITEMS 85 AND 86 - PROVIDER SIGNATURE AND DATE
The provider or the authorized representative must sign item 85. Indicate the month, day, and year the form is signed in item 86.

NOTE: This may be a computer printed name and date, or a signature stamp.

ATTACHMENT 2



APPROVED OMB NO. 0938-0279

IM Provider
1 W. Williams Street
Anytown, WI 55555

3 PATIENT CONTROL NO: 1234JCD
4 TYPE OF BILL: 721
5 FED TAX NO
6 STATEMENT COVERS PERIOD: FROM 100893 THROUGH 100893
7 COV D: 1
8 N-C D
9 C-H D
10 L-R D
11

12 PATIENT NAME: Recipient, Im A
13 PATIENT ADDRESS: 609 Willow Anytown, WI 55555

14 BIRTHDATE | 15 SEX | 16 MS | 17 ADMISSION DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO | CONDITION CODES | 31

32 OCCURRENCE CODE / DATE | 33 | 34 OCCURRENCE CODE / DATE | 35 OCCURRENCE SPAN CODE / FROM / THROUGH | 37 A B C

38

39 VALUE CODES CODE / AMOUNT | 41 VALUE CODES CODE / AMOUNT

	42 REV. CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	300	Laboratory	82340		3	XX XX		
2	300	Laboratory	82570		2	XX XX		
3	300	Laboratory	83945		1	XX XX		
4	821	Dialysis			5	XXX XX		
5								
6	001	Total Charges				XXX XX		
7								
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23								

50 PAYER: WI-Medicaid
51 PROVIDER NO: 87654321
52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST AMOUNT DUE | 56

57 DUE FROM PATIENT

58 INSURED'S NAME | 59 P.REL | 60 CERT. - SSN - HIC - ID NO: 1234567890 | 61 GROUP NAME | 62 INSURANCE GROUP NO

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN DIAG. CD: 5920
68 CODE | 69 CODE | 70 CODE | OTHER DIAG. CODES 72 CODE | 74 CODE | 76 ADM DIAG. CD | 77 E-CODE | 78

79 P.C | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS: OI-D

85 PROVIDER REPRESENTATIVE: X IM Authorized
86 DATE: MMDDYY

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB-92 HCFA-1450
OCR/Original